SOUTH DAKOTA HEALTH PROFESSIONALS ASSISTANCE PROGRAM
4400 WEST 69TH STREET #600 ◆ SIOUX FALLS SD 57108
(605) 310-2426 ◆ FAX: (605) 362-3541

To the practitioner of the Health Professionals Assistance Program Participant:

Please take a few moments to complete this form, and then mail the completed form to the South Dakota HPAP office. The form must be completed by the practitioner only. If you have any questions, please contact the South Dakota HPAP office.

NAME OF PARTICIPANT: _____

(PLEASE PRINT)

PRESCRIPTION INFORMATION				
	DATE OF PRESCRIPTION	TYPE OF MEDICATION	QUANTITY & DOSAGE PRESCRIBED NUMBER OF REFILLS	REASON FOR MEDICATION
1				
2				
3				

I have been informed that this patient is participating in the SD HPAP.

PRACTITIONER NAME (PLEASE PRINT): _____

PRACTITIONER SIGNATURE: _____

DATE: _____

OFFICE TELEPHONE: _____

ADDRESS: _____